2021 Annual Practice Enhancement Seminar

Tennessee Academy of Family Physicians

Telehealth for 2021: Current State

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Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or
  - 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS Coding Guidelines rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.
- I disclose no other conflicts.

Objectives

- Define "Telehealth" and know where to find the active file for telehealth services covered by Medicare and the most recent updates and additions
- Be able to state the various Telehealth applications in primary care and best practice billing processes
- Know which quality metrics can be captured with Telehealth in 2021

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - Virtual Check-ins
  - On-line digital Management (E-visits)
  - Telephone encounters and other waivers

Telemedicine

- Medicare telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider who is at a separate location using an interactive 2-way telecommunications system (like real-time audio and video).
- These services were previously only available in rural areas, under certain conditions, for ESTABLISHED patients located at one of these places:
  - A doctor's office
  - A hospital
  - A Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)
  - A skilled nursing facility
  - A community mental health center (if substance use disorder or co-occurring mental health disorder, can get from home)
  - A dialysis clinic and with home dialysis (after 1x/mo in-person visits, then q 3 mo in-person)

Telehealth waivers from CMS

- Temporary policy changes during the Coronavirus pandemic
- CMS has issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 Public Health Emergency.
- Some of these changes allow providers to:
  - Conduct telehealth with patients located in their homes and outside of designated rural areas
  - Practice remote care, even across state lines, through telehealth
  - Deliver care to both established and new patients through telehealth
  - Bill for telehealth services (both video and audio-only) as if they were provided in person
  - Include RHC in telehealth expansion
- Current PHE goes until April 21, 2021 (some services are covered until EOY of PHE) https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telemedicine

- Prior to waiver, all needed to be HIPAA compliant
  - This is a real-time concurrent session where interactive Q/A and medical decision-making occur just like in the standard face-to-face (FTF) office visit.
  - Since waiver, HIPAA violations will be waived to increase access and other "everyday communications technologies" are allowed. Documentation in your record needs to note method and other info as if standard FTF encounter performed.
    - May use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk during the COVID-19 PHE.
    - Notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
    - Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should <u>not</u> be used

Telemedicine Coding

- The same E/M CPT codes are used with the same reimbursement; co-pay/deductibles apply
  - 99202-99215; G0245-G0247 (ED/IP consults); G0406-G0408 (f/u IP consults hospital/SNF); preventive and other services
- Documentation is still accountable, exam will be hindered without advanced technology (follow 2021 E&M Guidelines)
- Modifiers and Place of Service (POS) codes – main ones:
  - CS: Waives cost sharing. Use only in ov where COVID test/labs ordered
  - -95 Modifier: Denotes video visit for Telemedicine
  - See Resource handouts and grab a billing staffer to follow the links…
    - Some for Part B, for Part A, for both, for RHC/FQHC (or optional) and most only for PHE ….

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - **Virtual Check-ins: not Telehealth. "Technology-based"**
  - On-line digital Management (E-visits)
  - Telephone encounters, and other waivers

Virtual Check-in

- "Check-in" with provider using a phone, integrated audio/video system, or captured video image
- Provider can respond using:
  - Phone
  - Audio/video visit
  - Secure text messages or Email
  - Use of a patient portal
- Standard Part B pricing (co-pay/deductible applied until waiver)

Virtual Check-ins: G2012 and G2010

- G2012: A brief (5-10 min) check-in with provider via telephone or other telecommunications device to decide whether an office visit or other service is needed (0.25 wRVUs/~$14)
  - Initiated from an established patient. Need consent. Not co-insurance waived
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Document content of conversation, plan. Include TIME duration of call.
- G2010: Remote evaluation of recorded video/image submitted by an established patient (including interpretation with f/u with the patient within 24 hours). (0.18 wRVUs/~$12)
  - Can do but **not** if originating from a related E/M service within the last 7 days nor leading to an E/M service or procedure within the next 24 hours
  - Need consent. Co-insurance not waived.

Technology-based CMS Coverage

- CMS will cover three types of "virtual" healthcare encounters
  - Telemedicine
  - Virtual Check-ins
  - **On-line digital Management (E-visits)**
  - Telephone encounters, and other waivers

Evaluation and Management: On-line Digital Services

- CPT developed 3 new codes for physicians and NPPs (NPs, PAs, CNSs)
  - Takes the place of former code 99444 (…on-line E/M service by …) never paid by CMS, others
  - Brief, on-line E/M services when using a secure platform and initiated by established patient
  - Timed, specific to work done by providers who can bill for E/M services. Staff time does not count
  - Time is counted during a 7-day period
    - Starts when patient-initiated service is reviewed, evaluated, and managed by PROVIDER
      - Questions addressed, chart review, management plans developed, subsequent communication (email, call, digitally supported contact)
  - Also: document in permanent record, if FTF w/in 7d then it is bundled in (no bill for this), if < 7 days after FTF then no bill, not in global surgical period if surgeon billing, and only once in 7d.

CPT Professional Edition, 2020. AMA, p. 68.

99421-99423 On-line Digital Management

- 99421
  - 5-10 minutes of cumulative time
  - 0.25 wRVUs ($15)
- 99422
  - 11-20 minutes of cumulative time
  - 0.50 wRVUs ($31)
- 99423
  - > 20 minutes of cumulative time
  - 0.80 wRVUs ($47)
- Problem: tracking of time, cross-over of service delivery, marketing

Evaluation and Management: On-line Digital Services

- CPT developed 3 new codes for NON-providers
  - Brief, on-line E/M services when using a secure platform and initiated by established patient
  - Timed, specific to work done by qualified nonphysician healthcare professionals who CANNOT bill for E/M services.
    - Dietitians, Social Workers, PTs, OTs, SLPs, etc.
  - Time is counted during a 7-day period
    - Starts when patient-initiated service is reviewed, evaluated, and managed by QNHP
      - Questions addressed, chart review, management plans developed, subsequent communication (email, call, digitally supported contact)
  - Also: document in permanent record, if FTF w/in 7d then it is bundled in (no bill for this), if < 7 days after FTF then no bill, not in global surgical period if surgeon billing, and only once in 7d.

CPT Professional Edition, 2020. AMA, p. 40

98970-98972 On-line Digital Management **QNHP**

- 98970
  - 5-10 minutes of cumulative time
- 98971
  - 11-20 minutes of cumulative time
- 98972
  - > 20 minutes of cumulative time
- Problem ……**CMS says NO! NO wRVUs assigned to this.**

Non-Provider On-line Digital Services (CMS)

- CMS developed 3 new HCPCS codes for NON-providers
  - Brief, on-line "assessments" when using a secure platform and initiated by established patient
  - Timed, specific to work done by qualified nonphysician healthcare professionals who CANNOT bill for E/M services. These are ASSESSMENTS.
    - Dietitians, Social Workers, PTs, OTs, SLPs, etc.
  - Time is counted during a 7-day period
    - Starts when patient-initiated service is reviewed, assessed by QNHP
      - Questions addressed, chart review, management plans developed, subsequent communication (email, call, digitally supported contact)
  - Also: document in permanent record, if FTF w/in 7d then it is bundled in (no bill for this), if < 7 days after FTF then no bill, not in global surgical period if surgeon billing, and only once in 7d and no double-dipping with other services (CCM, etc.)

CPT Professional Edition, 2020. AMA, p. 40

G0261-G0263 On-line Digital Management (CMS)

- G2061
  - 5-10 minutes of cumulative time
  - 0.25 wRVUs ($12)
- G2062
  - 11-20 minutes of cumulative time
  - 0.44 wRVUs ($21)
- G2063
  - > 20 minutes of cumulative time
  - 0.69 wRVUs ($34)
- Problem: tracking of time, cross-over of service delivery, marketing

On-line Digital Management/Assessment

- Do not bundle with other billable codes that cross over
  - *NEW CODES, so be wary.*
  - *Yearly consent – verbal OK, but note in chart.*
  - *Looks OK for TCM (but I would not go there)*
  - *Worry about CCM and CPO (so, I would not go there either)*
  - *7d before …. 7d after do not use or will lose the E/M of the office visit or other encounter (payors usually pay the lesser code billed together)*
- These are generally asynchronous communications from patients, telemedicine is real-time
- Example ……

Examples of Digital Management Encounter

- Acute complaint sent to your NPP, and email is addressed with review of record, reply of email and send in meds to pharmacy (5 min). Patient replies back tomorrow with f/u and new complaint. NPP addresses and add another med. (4 min). Total time is 9 minutes.
  - Bill 99421 (all comers) ….. Or hold in que for now until 7d later, then bill → $15
- RD counseling issue. Review of food log, exercise plan. Return email with several interchanges to address patient's questions (12 minutes). Tomorrow, new issues arise re diet plan and there is a to/fro email exchange with the patient (13 min). Total time = 25 minutes.
  - Bill G2063/98972 ….. Or hold in que for now until 7d later, then bill → $34 (CMS)
- **NOT** co-pay/deductible waived…..so educate before you deploy! Consent.

Telehealth/TelePHONE Flexibility in Pandemic

- Medicare has loosened the requirements for several services during the PHE (expect this to go through April 21, 2021 at a minimum)
- Of Note…
  - Medication Reconciliation post discharge (TCM), but also CPTII 1111F (30d)
  - DMARD, Osteoporosis Rx, Statin Use in CV and DM can be closed if Rx filled
  - Care for Older Adults (COA) Medication Reconciliation
  - The Initial or Subsequent Annual Wellness Visit is eligible to be done by PHONE only
    - Flexibilities regarding vitals that are required
    - Still perform PHQ2/9, GAD-7, MMSE (Sweet 16) and since by phone, do the STEADI for falls risk
  - The IPPE is still FACE-TO-FACE ONLY

Quality Measure

- This process of BP collection DOES close the BP quality measure since this takes home info and the quality measure requires FTF in office capture.
- However, any office collection of the BP that day WOULD close the quality measure (<140/<90). Recall this is the LAST BP of the year collected.
- With MWV by phone, opportunities to use telecommunications exist …

Stopping Elderly Accidents, Deaths, and Injuries

- STEADI
  - Screen → Assess → Intervene
- Screening
  - Three key questions and if YES for any, then are at risk
    1. Do you feel unsteady when standing or walking?
    2. Do you have worries about falling?
    3. Have you fallen in the past year? (if yes, ask how many times and if they were injured). FALLING makes the patient at risk and further assessment is needed

STEADI: "Stay Independent" Risk Score

- Stay Independent: 12 questions. If score 4 or more, are at risk (further assessment) OR if the patient has fallen, then at risk and further assessment is needed

1. I have fallen in the past year. (if yes, then at risk and needs further assessment)
2. I use (or have been advised to use) a cane/walker to get around.
3. Sometimes I feel unsteady when walking
4. I need to hold on to furniture to steady myself when walking at home.
5. I am worried about falling.
6. I need to push with my hands to stand up from a chair.
7. I have some trouble stepping up onto the curb.
8. I often must rush to the toilet due to bowel or bladder urgency issues.
9. I have lost some feeling in my feet.
10. I take medications that sometimes makes me feel light-headed or more tired than usual.
11. I take medications to help me sleep or improve my mood.
12. I feel sad or depressed.

(Rubenstein et al. J Safety Res; 2011: 42(6)493-499)

Advance Care Planning (ACP)

- The Face-to-Face conversation between a physician (or other qualified health care professional) and a patient to discuss wishes relating to medical treatment if they were unable to speak or make decisions for themselves. This can be performed with the IPPE or AWV at the patient's discretion. *In this context, with -33, it is co-pay/deductible waived*
- Explain and discussion of advance directives, forms (including completion of such –HCPOA, living will, etc.) with patient, family, and/or surrogate. Need ICD-10 diagnosis.
  - 99497 first 30 minutes 1.5 wRVU (2021)
  - 99498 each additional 30 minutes 1.4 wRVU (2021)

Intensive Behavioral Therapy – Cardiovascular Disease

- CV disease is the leading cause of mortality in the US
  - CV disease is comprised of HTN, CAD, HF, and stroke
- Leading cause of hospitalizations, even though overall adjusted mortality rate has declined over past 10 years
  - Risk factors:
    - Overweight (BMI>25) and greater with increasing obesity
    - Physical inactivity
    - HTN
    - Hyperlipidemia
    - +FH MI
    - Increased risk with increased age
- CMS has determined that the evidence is present to conclude that IBT for CV Disease prevention is reasonable and necessary.

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=348&ncdver=1&bc=AgAAgAAAAAAA&

IBT – CVD Risk Reduction Visit

- The CV Risk Reduction intervention should focus on
  - Encouraging aspirin use for the primary prevention of CVD when the benefit outweighs the risk for men (45-79) and women (55-79)
  - Screening for hypertension in adults >18 (<140/<90)
  - Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known CV risk factors for CV and other diet-related chronic disease
- "We note that only 4% of the Medicare population is <45 (M) or 55 (F), so the vast majority of beneficiaries should receive all three components"
- "IBT counseling to promote a healthy diet is broadly recommended to cover close to 100% of the population due to the prevalence of known risk factors."

IBT – CVD Risk Reduction Visit

- Coverage is ONE FTF* visit per year
  - The discussion re: ASA and primary prevention should cover the "Five A's" approach
    - Assess: Ask about behavioral health risk(s) and factors affecting choice of behavior change goals/methods
    - Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits
    - Agree: Collaboratively select treatment goals and methods based on the patients' interest in and willingness to change the behavior
    - Assist: Aid in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
    - Arrange: Schedule follow-up contacts to provide ongoing assistance/support and to adjust the treatment plan as needed, including referrals

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Food for Thought

- The CV Risk Reduction intervention should focus on
  - ***Encouraging aspirin use for the primary prevention of CVD when the benefit outweighs the risk for men (45-79) and women (55-79)***
- New trial data (2018) incorporated into a metanalysis that includes decades of trial experience on use of ASA in primary prevention
  - Early trials showed benefit of aspirin in reducing CV events, more recent trials have challenged these findings with even a signal towards net harm.
  - ARRIVE (*Lancet* 2018; 392:1036-46), ASCEND (NEJM 2018; 379:1529-39), ASPREE (NEJM 2018; 379: 1499-1528)
    - Clinical benefit in primary prevention is debatable, especially in 70 years of age and older
    - Avoid with prior bleeding issues (esp. for primary prevention)
- HAVE THE DISCUSSION, but educate on risk/benefit

IBT – CV Risk Reduction … more food for thought

- Screening for hypertension in adults >18 (<140/<90)
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known CV risk factors for CV and other diet-related chronic disease
  - Statin use
    - *Lancet* Borge Nordestgaard, MD (2020 Nov 10, Fam Prac News, 12.2020 pp1,24)
      - Lowering LDL cholesterol in healthy persons 70-100 the potential for preventing MI and ASCVD has a NNT lower than those 20-69 years of age.
    - *Lancet,* Baris Gencer, MD (2020 Nov 10, Fam Prac News, 12.2020 p 24)
      - LDL-lowering drugs in patients 75yoa and older showed less major CV events and improved outcomes with MI, stroke as in younger individuals with no offsetting safety concerns
  - DASH Eating Plan

DASH overview

- Focus on eating fruits, vegetables, and whole grains
- Prefer intake of fat-free or low-fat dairy products, fish, poultry, beans, nuts, and vegetable oils
- Limits on foods that are high in saturated fatty acids (like fatty meats, full dairy products, and tropical oils like coconut, palm kernel and palm oils)
- Limits on sugar-sweetened beverages and snacks
- BP Benefit seen within two weeks in initial trial

IBT – Billing and Coding

- G0446: Annual, face-to-face** intensive behavioral therapy for cardiovascular disease, individual, 15 minutes (>7½ min)
  - 0.45 wRVUs (~$25)
  - If with Initial/Subsequent AWV or the IPPE is no co-pay or deductible. No modifier.
  - Outside of MWV, use -25 and co-insurance may apply
- Use any diagnoses related to conditions that increase CV risk (HTN, Obesity, DM, hyperlipidemia, CVA, etc.)
  - If none, use Z13.6, screening for cardiovascular disease
- Annual (w/ MWV). Telehealth allowed with PHE**.

Intensive Behavioral Therapy – Obesity

- National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity (210.12)
  - Obesity is "epidemic" in the US
  - Directly associated with multiple chronic diseases and musculoskeletal conditions (CV, DM, etc.)
- G0447 — Face-to-face behavioral counseling for obesity, 15 minutes.
  - 0.45 wRVU (~$25)
- G0473 — Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes
  - 0.23 wRVU (~$12.50)
- BMI 30+
  - Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45
- Co-pay/deductible waived with MWV, no modifier. Telehealth allowed with PHE.

IBT– Obesity Parameters

- Medicare pays up to 22 visits billed with the codes G0447 and G0473, combined, in a 12-month period:
  - **First month:** 1 face-to-face visit every week
  - **Months 2–6:** 1 face-to-face visit every other week
  - **Months 7–12:** 1 face-to-face visit every month if the patient meets certain requirements
- At the 6-month visit, you must perform a reassessment of obesity and a determination of the amount of weight loss.
- If the patient loses at least 3 kg (6.6#) during the first 6 months they're eligible for additional face-to-face visits occurring once a month for months 7–12. Must document such in records (BMI, weight loss amount)
- If not …."reassess their readiness to change"

Depression Screening

- Of those > 65 years of age, 1 in 6 suffers from depression, and those with co-morbid conditions increase the # closer to 25% in that group
- 75% of older adults who committed suicide saw their PCP in the prior month – 39% saw the PCP the prior week – of their suicide
- G0444: Annual Depression Screening, 15 minutes (50% threshold). Telehealth with PHE.
- No mandated screening tool (part of I-AWV/IPPE). I recommend this be provider delivered (staff set-up OK) and discussed after staff set-up. (PHQ2/9)
- Physician/Provider performed is best, but there is an option to have this collected by staff ("incident to") but restrictions of having a "staff-assisted decision care support" (indications of a nurse or PA to get abnormal info to the physician for decision-making)
- Screening with PHQ-2/-9 would not break 7½ min threshold (so maybe only consider if screen abnormal and treatment discussion ensues) – NOTE TIME

Depression Screening

- Depression risk screen: PHQ-2 or PHQ-9
- When screening for depression the Patient Health Questionnaire (PHQ-2) can be used first (it has a 97% sensitivity and a 67% specificity).
  - If positive, the PHQ-9 can then be used, which has 61% sensitivity and 94% specificity in adults.
- The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria as "0" (not at all) to "3" (nearly every day). It has been validated for use in primary care
- It is not a screening tool for depression, but it is used to monitor the severity of depression and response to treatment.
  - Can be used to make a tentative diagnosis of depression in at-risk populations - eg, those with coronary heart disease or after stroke.

Scoring PHQ2/9

- PHQ-2 consists of the first two PHQ-9 questions
  - Score 0→3 (not at all → nearly every day) over last 2 weeks
  - Score ranges 0→6 and if one scores 3 or higher, the PHQ-9 is performed
- PHQ-9
  - 7 additional questions with question #9 referring to suicidal thoughts
  - Each question has the same scoring as PHQ-2
  - Boxes are "shaded" (2 and 3 column) and if 4 or more are checked depression should be considered. All 3 columns of question 9 are shaded
    - SCORE:

1→4	Minimal depression
5→9	Mild depression
10→14	***Moderate depression***
15→19	***Moderately severe depression***
20-27	***Severe depression***

Depression Screening

- G0444: Annual Depression Screening, 15 minutes (50% threshold)
  - 0.18 wRVU (~$18)
- Use code Z13.31 (depression screen)
- Cannot be billed on the IPPE or the Initial AWV (already required), but can be billed with the subsequent AWV and if so, is waived
- Once per year (after 11 full months). Use -25 if not in subsequent AWV.

Depression Screening Tools

- Full library of depression screening tools
  - https://www.apa.org/depression-guideline/assessment
  - Beck Depression Inventory: aged 13-80. 21 self reported questions. 10 min
  - Center for Epidemiologic Studies Depression Scale (CES-D): primary care, 6 and up. 20 minutes
  - EQ-5D: Health-related quality of life. Adolescent to adult. 5 minutes.

Initial/Subsequent AWV and Depression Screening

Initial AWV: *DO NOT BILL Depression Screening*

- Review the patient's potential risk factors for depression, including current or past experiences with depression or other mood disorders
- You may select from various available standardized screening tools designed for this purpose recognized by national professional medical organizations.
- For more information on depression screening, refer to the Depression Assessment Instruments website.

Subsequent AWV: *Check with your Carrier, but I say BILL Depression Screening*

- Update the patient's list of risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway
  - Include the following:
    - Mental health conditions including depression, substance use disorders, and cognitive impairment
    - Risk factors or conditions identified
    - Treatment options and associated risks and benefits

Screening and Behavioral Counseling for Alcohol

- Screen for misuse (G0442) and counsel if screening is positive (G0443)
  - Both are "15 minutes" (>7 ½ min threshold)
- For those who screen positive, Medicare also pays for a brief face-to-face behavioral counseling session, HCPCS code G0443.
- **G0442** annual alcohol misuse screening, 15 minutes
  - Not bundled into MWV, so add on. If on office E/M, use -25 modifier, Co-insurance waived
  - Can be done in PCP office. Staff-directed screening allowed (PCP-directed)
    - Alcohol Use Disorders Identification Test (AUDIT), AUDIT-Consumption, etc.)
  - Use ICD Code Z13.39
- **G0443** Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes. 4x/year max
  - Not bundled into MWV, so add on. If on office E/M, use -25 modifier, Co-insurance waived
  - Counseling should be performed by PCP/QHCP and not clinical staff with incident to (NU)
  - Use ICD Code from the "F" code set

Behavioral Health Integration Team-based Option

- 10/2020 The American Medical Association (AMA) announced its participation in the Behavioral Health Integration (BHI) Collaborative
  - Joined seven other organizations (AAFP, ACP, AOA, APA, AAP, ACOG, and AACAP)
  - Information-sharing on
    - How to integrate primary care and psychiatry given the stress of supply/demand and the present COVID pandemic
    - Optimize care delivery (telehealth, etc.)
- This care model is delivered by a primary care physician and may be in conjunction with a care manager and in collaboration with a psychiatric consultant.

General Behavioral Health Integration (BHI)

- A care team of PCP and clinical staff that are focused on the behavioral health needs of a patient
  - Usually primary care, but can be of other subspecialties.
  - Clinical staff person does not need to be a behavioral health specialist, but it is preferred based on scope of work carried by them on the team
- Prior to starting the BHI services, an initiating visit is needed if the patient is new to the provider or has not been seen within 1 year
  - Time to assess the patient's need and alignment with the BHI services
  - Verbal consent is needed and should be noted in the chart (info-sharing)
  - Notify the patient of the co-insurance (applied)
  - TCM, AWV, IPPE, or 99202-99205, 99212-99215 visits count
  - Covered by Medicare, Commercial (check), but NOT Medicaid

99484: General BHI

- Bill if the 20 minutes of time is performed personally by the physician/NPP
  - Clinical staff can assist in care delivery
- Use validated rating scales such as the depression scale, behavioral health care planning and revisions to the plan facilitating and coordinating treatment with the patient's input and PCP direction
- Like codes 99492, 99493 and 99494, the supervision requirement is general not direct. That means, the physician/NPP does not need to be in the office when the staff member is performing the service.
- Can be billed with Chronic Care Management. Not with CoCM codes.
- (0.61 wRVU/$47) – telephonic or FTF

Psychiatric Collaborative Care Management (CoCM)

- Care is patient-focused with the team all coordinated on helping reach goals, improve mental health using the psychiatrist as distant consultant
- Structured care management program
- Regular assessments via validated tools that direct treatment modifications as appropriate
- Psychiatrist provides consultation to the primary care team with recommendations for care and the PCP then determines which path to take based on team's recommendations.
  - The PCP-patient relationship remains key and care remains "local" while team is usually remote

Psychiatric CoCM

- **99492** Initial psychiatric collaborative care management, first 70 minutes of behavioral care manager activities.
  - In consultation with a psychiatrist
  - Under direction of the PCP who consults with the team in making treatment decisions in alignment with the CoCM Care Plan
  - Initial assessment, use of validated treatment scales, development of treatment plan
  - Using a patient registry to track follow-up and progress. Weekly caseload consultation with psychiatrist
  - Deploy motivational interviewing, behavioral activation and other evidence-based techniques
  - (1.88wRVU/$154) – telephonic or FTF

Psychiatric CoCM

- **99493** Subsequent month psychiatric collaborative care management, first 60 minutes of behavioral care manager activities.
  - In consultation with a psychiatrist
  - Under direction of the PCP who consults with the team in making treatment decisions in alignment with the CoCM Care Plan
  - Use of validated treatment scales, development of treatment plan, brief interventions for patients not progressing
  - Using a patient registry to track follow-up and progress. Weekly caseload consultation with psychiatrist
  - Deploy motivational interviewing, behavioral activation and other evidence-based techniques
  - (2.05 wRVU/$154) - telephonic or FTF

Psychiatric CoCM

- **99494** Subsequent month psychiatric collaborative care management, each additional 30 minutes of behavioral care manager activities.
  - This is an added code for services done in the month (add to 99492 or 99493)
  - Document well the added work needed
  - (0.82 wRVU/$40) - telephonic or FTF

CoCM and General BHI

- BHI is for the PCP who performs this duty on in conjunction with their staff (>20 min). Staff must be clinical. Bundled in if CoCM done same month
- CoCM must deploy an integrated team with a behavioral care manager and psychiatrist. Use a registry. IT integration is needed.
- Both models need time tracking and good documentation and both allow the care to be delivered closer to home where patients should be more at home with the care as long as the PCP is managing the care.

Hypertension Treatment Plans

- "Over the last 15 years, many studies indicate that up to one-half of people with hypertension report using SMBP monitors." (Rakotz, AMA TargetBP ref article, 11/2019)
- 2015–2016 DocStyles survey of >1,500 PCPs and NPs suggests that ~97% of the survey respondents reported using SMBP with their patients
- USPSTF has updated its recommendations for screening for high blood pressure.
  - In clinical setting small number of measurements and patients may be nervous, that may lead to inaccurate results for blood pressure measurement
  - Blood pressure monitoring outside of the office is effective for confirming hypertension. (American Medical Association CPT® and RBRVS 2020 Annual Symposium)

Hypertension Treatment Plans

- 99473
  - Physician or staff provide training on device and calibrate such to show accuracy. Show how to take BP at home. (https://targetbp.org/tools)
    - Perform one time per device (note such need)
    - 0.31 TOTAL RVUs ($11.19). NO wRVUs here
- 99474
  - Data collection reported to provider with average of SBP and DBP with any subsequent communication reviewed over 30-day period. Minimum 12 readings (recommend a series of 2 readings, 1 minute apart, 2x/day). Develop treatment plan.
    - Perform up to 1x/month
    - 0.18 wRVU ($14)

Hypertension Assessment and Plan Restrictions

- Do not report when any of these are used in the same month:
  - Ambulatory blood pressure monitoring: 93784, 93786, 93788, 93790
  - Remote monitoring of physiologic parameters: 99453, 99454
  - Physiologic data collection and interpretation, 30 minutes or more every 30 days: 99091
  - Remote physiologic monitoring treatment management services: 99457
  - Chronic care management services: 99487, 99489, 99490, 99491
- 99495 and 99496 are OK to bill (TCM)

Remote Patient Monitoring Services Update

- Expanding the ability for management of chronic disease
  - The new codes better suited to reimburse for the realities of current technology and staffing models. While CMS has not specified which types of technology are covered, the device used must be a medical device as defined by the FDA.
- 99453: Initial set up to monitor physiologic parameters (wt, BP, O_2 sat) and patient education on use of equipment
  - total RVU 0.52, NO wRVUs ($20)
- 99454: Supply devices, collect/transmit info to clinician.
  - total RVU 1.73, NO wRVUs ($69)
- 99457: Remote physiologic monitoring, first 20 min. by provider, QHCP. Pt interaction.
  - 0.61 wRVUs ($54)
- 99458: …for monitoring that exceeds 20 minutes. Pt interaction.
  - 0.61 wRVUs ($45)

Remote Patient Monitoring Services Update

- To bill on these codes, you'll need to check the following boxes:
  - The patient must opt-in for the service
  - Device must meet the FDA's definition of medical device
  - Device must be supplied for at least 16 days to be applied to a billing period
  - The service must be ordered by a physician or other qualified healthcare professional
  - Data must be wirelessly synced where it can be evaluated
  - The data-monitoring services may be performed by the physician, by a qualified healthcare professional or by clinical staff. Clinical staff may include RNs and medical assistants, depending on state law
- These are early days for the new RPM CPT codes. Medicare Advantage plans by default will reimburse on the fee schedule set by CMS; some states and commercial payers also reimburse on them. WATCH. Challenge.

TCM: Not Once and Done

- This is a 30-day code, so re-connecting with the patient is expected if there is need
  - Referrals
  - Community resources: Meals on Wheels, Senior Center, AA meetings, etc.
  - Home health initiation and transition
  - Physician/NPP request for close follow-up
    - Review note, how stable is patient
    - Make sure appointments kept and plan of care followed
- Transition to Chronic Care Management if appropriate
- Telehealth (not TelePHONE) is allowed for TCM w PHE

Remember…..TCM Revenue Value

Check the boxes, document the checks

- 99495: 2.78 wRVU (increased in 2020 and 2021)
  - Moderate MDM
  - < 14 days to be seen
- 99496: 3.79 wRVU (increased in 2020 and 2021)
  - High MDM
  - < 7 days to be seen (best practice for all hospital f/u care)
- 30-day code cross-over relaxed in 2020 and 2021, but caution with those codes
  - CCM (99490/491/493, 99487/89, and CPO (G0181, G0182) are allowed if medically necessary
- Don't forget code 1111F to show med reconciliation in the 3rd and 4th week (<30d)
- During the PHE is TeleHEALTH (not PHONE) allowed.

Transition Care Management (99495, 99496)

- For 2021 CMS has reduced the restrictions to billing, now OK to bill with
  - Non-Complex (99490) and Complex Case Management (99487, 99489)
  - Care Plan Oversight (G0181-G0182)
  - ESRD services for patients over 20 years of age (90960-90962, 90966, 90970)
  - Prolonged Services without direct patient contact (99358-99359)
  - Home and OP INR monitoring (93792-93793)
  - Interpretation of physiologic data (99091)

Closing…

- Check with your insurance carriers – especially after 04/21 for guidance on PHE waivers

- Questions….?

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